



STATE OF MAINE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF LICENSING AND REGULATORY SERVICES

**Children's Services Program**  
Family Child Care Application

<b>SECTION 1: Applicant Information</b>			
Applicant Name:			
Familiar Names (i.e. maiden name, aliases):			
Facility Name:			
Physical Address:			
City:	State:	Zip:	County:
Mailing Address:			
City:	State:	Zip:	County:
Date of Birth:	Telephone No.: (      )		Fax No.: (      )
Email Address:		Social Security No or State Tax ID:	

<b>SECTION 2: Fees</b>	
<b>APPLICATION FOR FAMILY CARE FACILITY</b>	
<p>License Type:</p> <p><input type="checkbox"/> <b>New License (fee \$80)</b> Provisional licenses are valid for one (1) year</p> <p><input type="checkbox"/> <b>Renewal License (fee \$160)</b> Renewal licenses are valid for two (2) years <b>License #:</b> _____</p> <p>(All information must be completed for renewals. Please do not reference prior submissions. Incomplete applications will be returned.)</p> <p><b>Total Fee Enclosed for application</b> ..... \$ _____</p>	
<p><b>Make check or money order payable to "Treasurer, State of Maine". Do not send Cash. Credit Cards are not accepted at this time. Application fees are non-refundable.</b></p> <p><b>Total Check/Money Order enclosed: =</b> \$ _____</p>	

*For questions regarding this program and/or application, please contact the following:*

Department of Health and Human Services  
Licensing and Regulatory Services  
Children's Services Program  
41 Anthony Ave; 11 State House Station  
Augusta, ME 04333-0011

Tel: (207) 287-5020      Fax: (207) 287-9304      Toll Free: 1-800-791-4080      TTY users call Maine relay 711  
Email: [info.dhhs@maine.gov](mailto:info.dhhs@maine.gov)      Web: <http://www.maine.gov/dhhs/dlrs/Licensing/children/daycare-nursery.html>

<b>Office Use Only:</b>				
Check#	MO #	Amount \$	Initials:	License#

**SECTION 3: Facility Information****Facility information:**

What year was the facility built? \_\_\_\_\_

Is this facility in a public school? ☐ No ☐ YesDo you have a swimming pool? ☐ No☐ Yes, indicate kind: ☐ Above-ground ☐ In-ground**Services:**What is the largest amount of children to be in your care at any time: ☐ 3-6 ☐ 7-12**Source of Water Supply:**☐ Municipal ☐ Well ☐ Other: \_\_\_\_\_☐ Check here if you do not need a water kit mailed to you.

Bottled water is optional if water is unsatisfactory.

**Directions to Facility (required):** Be specific and as detailed as possible. (No maps please)

---

---

---

---

---

---

---

---

---

---

Best time of day to visit: \_\_\_\_\_

**SECTION 4: Additional Staff**

Complete the following information for all people who will be working with children. Use additional paper if necessary.

Full Name:

Telephone No.: (       )

Social Security No.:

Home Address:

City:

State:

Zip:

County:

Full Name:

Telephone No.: (       )

Social Security No.:

Home Address:

City:

State:

Zip:

County:

**SECTION 5: Household Members**

List all household members other than the child care provider. Use additional paper if necessary.

Name	Date of Birth	Social Security No.	Relationship to Applicant
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**SECTION 6: Applicant Information** (Person legally responsible)

**Background:** (Please use additional sheets of paper if necessary.)

Are you now, or have you ever been licensed, registered or certified to provide services for children or adults??

- ☐ No  
☐ Yes, please indicate the type of care, approximate dates of service and name(s) under which you were licensed:

\_\_\_\_\_  
\_\_\_\_\_

Have you had any prior licensing sanctions issued to you, such as a conditional license, license suspension, denial of a licensing application, fine, or revocation regarding a child or adult care certificate or approval issued to you?

- ☐ No  
☐ Yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you, or has anyone employed by you, or has anyone living in or frequenting your home been involved in the following:

- |   |                             |                              |
|---|-----------------------------|------------------------------|
| 1) Convicted of a crime                                     | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 2) Involved in a child protective investigation             | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 3) Named as a defendant in a Protection from Abuse Order    | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 4) Had children removed from care or custody by court order | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

If you checked yes to any of the above, please explain:

\_\_\_\_\_  
\_\_\_\_\_

Have you ever been treated for drug and/or alcohol abuse?

- ☐ No  
☐ Yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you ever received mental health services?

- ☐ No  
☐ Yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Is there any other information that would be useful in assessing your ability to provide care for children?

- ☐ No  
☐ Yes, please explain: \_\_\_\_\_

\_\_\_\_\_

**SECTION 7: Submission**

Remember to submit the following documents with your completed application. **Incomplete applications will be returned.**

- A non-refundable check or money order made payable to "Treasurer, State of Maine"
- Authorization for Release of Information (Appendix A) **(Must be signed by all adult household members and/or staff/volunteers)**

**New applications** must also include the following documents:

- Three (3) references
- Training certificate(s), if applicable
- Floor plan

**SECTION 8: Declaration**

I/We have received, read and understand the **"Rules for the Certification of Family Child Care Providers"**, effective 7/1/2009. I/We understand that this application authorizes representatives of the Department of Health and Human Services and the State Fire Marshal's Office (if applicable) to make such visits and inspections as may be necessary to ensure that the facility is in compliance with the laws and rules pertaining to the operation of child care facilities.

I/We also understand that the signing of this application effectively serves as a release of information and gives permission to the Department of Health and Human Services to obtain any criminal, child protective and motor vehicle records for owner/operator/director which may be on file in any Country, State or Federal Office. Failure to disclose any criminal convictions, including operating under the influence (OUI), may result in denial of this application.

I/We understand any falsification of statement may be grounds for denial. I/We further certify that all information contained in this application is complete and accurate.

---

**Print name of Applicant**

---

**Signature of Applicant**

---

**Date**

---

**Print name of Co-Applicant**

---

**Signature of Co-Applicant**

---

**Date**

## Authorization for the Release of Personal History Information for ALL Adult Members of Household/Staff

### Provider's Section:

By signing below, I authorize the release of confidential records or information regarding any **criminal record, child protection record or motor vehicle record** to the Department of Health and Human Services, Division of Licensing and Regulatory Services.

I understand that any information obtained as a result of this release of information will remain confidential, as required by law, and will be used solely for the purpose of determining whether a license or approval to operate a children's daycare or other license should be granted or renewed.

Also, if any criminal record, child protection record or motor vehicle record indicates that a prior conviction or finding exists, the applicant will need to provide evidence to the Division of Licensing and Regulatory Services that any prior history has been addressed and the individual will not compromise or threaten the safety of any children to be cared for by the applicant.

This consent may be revoked by me, in writing, at any time, except that information that has already been obtained.

I understand that each adult member of my household or staff/volunteers must complete the lower portion of this form and that failure to do so will invalidate my application.

Applicant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Familiar Names (i.e. maiden name, aliases): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone No.: (\_\_\_\_) \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Adult Household Member's and Staff/Volunteer's Section:

By signing below, adult household members and staff/volunteers authorize the Department of Health and Human Services, Division of Licensing and Regulatory Services to disclose confidential records or information regarding that person's criminal, child protection, or motor vehicle record to the applicant/provider. Failure to disclose any criminal convictions, including operating under the influence (OUI), may result in denial of this application.

#### Adult Household Members' and Staff/Volunteers' Information:

Full Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Former/Maiden Name(s): \_\_\_\_\_

Social Security #: \_\_\_\_\_

Signature: \_\_\_\_\_

Full Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Former/Maiden Name(s): \_\_\_\_\_

Social Security #: \_\_\_\_\_

Signature: \_\_\_\_\_

Full Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Former/Maiden Name(s): \_\_\_\_\_

Social Security #: \_\_\_\_\_

Signature: \_\_\_\_\_

Full Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Former/Maiden Name(s): \_\_\_\_\_

Social Security #: \_\_\_\_\_

Signature: \_\_\_\_\_